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Department of
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www.dhsspsni.gov.uk

Equality Screening, Disability Duties and Human Rights Assessment Template

Part 1 – Policy scoping

Part 2 – Screening questions

Part 3 – Screening decision

Part 4 – Monitoring

Part 5 – Disability Duties

Part 6 – Human Rights

Part 7 – Approval and Authorisation

Guidance notes are available to assist with completing this template. For further help please contact the Equality and Human Rights Unit ext 20539.

Part 1. Policy scoping

1.1 Information about the policy / decision

1.1.1 What is the name of the policy / decision?

The Service Framework for Older People

1.1.2 Is this an existing, revised or a new policy / decision?

New policy

1.1.3 What is it trying to achieve? (intended aims/outcomes)

Generally the aim of Service Frameworks is to set out the standards of care that service users, their carers and wider family can expect to receive in order to help people to:

- prevent disease or harm;
- manage their own health and wellbeing, including understanding how lifestyle affects health and wellbeing including the causes of ill health and its effective management;
- be aware of what types of treatment and care are available within health and social care; and
- be clear about the standards of treatment and care they can expect to receive.

The aim of the Service Framework for Older People is to improve the health and wellbeing of older people, their carers and their families by promoting social inclusion, reducing inequalities in health and social wellbeing, and improving the quality of care.

The Service Framework for Older People sets explicit standards for health and social care that are evidence-based and are capable of being measured. Standards have been developed in relation to:

- Person Centred Care
- Health and Social Wellbeing Improvement
- Safeguarding
- Carers
- Conditions More Common in Older People
- Medicines Management
- Transitions of Care

1.1.4 If there are any Section 75 categories which might be expected to benefit from the intended policy, please explain how.

Age (Older people)
One of the aims of this Service Framework is to reduce health and social care inequalities for older people in Northern Ireland. This will attempt to ensure that equality of opportunity and human rights in health and social care will be promoted across all age groups, including older people.

Dependants (Carers)
Government policies outline the need to "ensure that service providers make practical support for carers a high priority" with the recognition that the continuing contribution of carers provide the "backbone" of caring for people in the community. This Service Framework contains a set of standards aimed explicitly at carers, including: supporting carers; information for carers; respite for carers; and carer health and wellbeing.

Others
While the main focus is older people and carers it is expected that others will benefit, for example in relation to Independent Advocacy it is acknowledged that for a whole raft of reasons (age, disability, mental health issues, gender, ethnic origin, sexual orientation, social exclusion, reputation, abuse and family breakdown and living away from home or in institutions), some people may also feel discriminated against or simply excluded from major decisions affecting their health and wellbeing. It is at such times that independent advocacy can make a real difference because it gives people a voice; helps them access information so that they can make informed decisions and participate in their own care or treatment.

In addition, as women generally live longer than men it is more likely that that they will need care for a longer period of time. At the same time it is also possible that men may need this care at any earlier stage of their lives.

1.1.5 Who initiated or wrote the policy?

Initiated by DHSSPS as part of the Service Framework programme. It was written by project leads in the HSC Board and Belfast Trust, with input from other HSC bodies.

1.1.6 Who owns and who implements the policy?

The policy is owned by DHSSPS and is implemented by the HSC Trusts. Monitoring will be undertaken by the HSC Board / PHA.

1.2 Implementation factors

Are there any factors which could contribute to/detract from the intended aim/outcome of the policy/decision? If yes, are they

Financial	X	While many of the standards do not require additional resources to implement, for others there may be additional costs. The ability to deliver all of the standards may be affected by the currently challenging financial position.
Legislative		
Other		

1.3 Main stakeholders affected

Who are the internal and external stakeholders (actual or potential) that the policy will impact upon?

Staff	X
Service users	X
Other public sector organisations	X
Voluntary/community/trade unions	X
Other, please specify	

1.4 Other policies with a bearing on this policy / decision. If any:

Policy	Owner(s) of the policy
Ageing in an Inclusive Society (2005)	OFMDFM
Living Matters Dying Matters (2010)	DHSSPS
Quality 2020 (2011)	DHSSPS

Transforming Your Care (In Development) The Reform of Adult Care and Support (In Development) In addition, as appropriate further policies are listed in the Framework Document under the evidence sections of each standard.	DHSSPS DHSSPS

1.5 Available evidence

What evidence/information (both qualitative and quantitative*) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

Section 75 category	Details of evidence/information
Religious belief	The religious breakdown by age recorded in the 2011 Census for those age 65 and over indicates that:-

Catholic	84,143
Presbyterian Church in Ireland	72,001
Church of Ireland	50,570
Methodist Church in Ireland	12,170
Other Christian (including Christian related)	16,430
Other religions	1,704
No religion	10,730
Not stated	15,972
TOTAL	**263,720**

<table>
<tr><td>Political opinion</td><td>There is limited data available, however, data on the first preference votes per party in NI Assembly Elections 2011, from the Electoral Commission can be used as proxy information:
DUP -198, 436
Sinn Fein – 178,222
UUP – 87,531
SDLP – 94,286
Alliance – 50,875
Other - 52,384

(Electoral Office NI, 2011)</td></tr>
<tr><td>Racial group</td><td>The ethnic group by age recorded in the 2011 Census for those age 65 and over is shown in the table below.

<table>
<tr><th></th><th>Males</th><th>Females</th><th>Total</th></tr>
<tr><td>White</td><td></td><td></td><td></td></tr>
<tr><td>White</td><td>114,156</td><td>148,664</td><td>262,820</td></tr>
<tr><td>Irish Traveller</td><td>42</td><td>41</td><td>83</td></tr>
<tr><td>Asian</td><td></td><td></td><td></td></tr>
<tr><td>Chinese</td><td>123</td><td>119</td><td>242</td></tr>
<tr><td>Indian</td><td>140</td><td>94</td><td>234</td></tr>
<tr><td>Pakistani</td><td>27</td><td>19</td><td>46</td></tr>
<tr><td>Bangladeshi</td><td>5</td><td>4</td><td>9</td></tr>
<tr><td>Other Asian</td><td>15</td><td>33</td><td>48</td></tr>
<tr><td>Black</td><td></td><td></td><td></td></tr>
<tr><td>Caribbean</td><td>4</td><td>4</td><td>8</td></tr>
<tr><td>African</td><td>15</td><td>10</td><td>25</td></tr>
<tr><td>Other</td><td>7</td><td>6</td><td>13</td></tr>
<tr><td>Mixed</td><td>40</td><td>24</td><td>64</td></tr>
<tr><td>Other</td><td>64</td><td>64</td><td>128</td></tr>
<tr><td>TOTAL</td><td>114,638</td><td>149,082</td><td>263,720</td></tr>
</table>

NISRA website Table DC2101NI
According to the All Ireland Traveller Health Study (AITHS), the Traveller population in Northern Ireland is estimated at 3905, with1562, families. The age profile of this community</td></tr>
</table>

is markedly different from that of the general population with 70% of Travellers aged 30 or under, and only 1% aged 65 and over. This reflects in part a higher birth rate, higher mortality rates and inward migration rates.

The number of requests received by the NI HSC Interpreting Service has risen from 10,257 in 2005/6 to 63,868 in 2011/12.

The upward trend has continued and in the last quarter of 2012/13 20,408 requests were received.

NIHSCIS Languages 1 January - 31 March 2013

Polish	7087
Lithuanian	3743
Portuguese	1941
Chinese - Mandarin	1170
Slovak	1053
Tetum	875
Russian	798
Chinese - Cantonese	753
Hungarian	595
Latvian	554
Romanian	478
Arabic	399
Somali	231
Czech	175
Bulgarian	146
Chinese - Hakka	86
Bengali	76
Spanish	54
Italian	43
Urdu	24
Farsi	16
Punjabi	16
French	14
German	13
Thai	11
Hindi	9
Japanese	8
Malayalam	8

Slovenian	6	
Albanian	5	
Tagalog	4	
Nepali	4	
Pashto Central	3	
Ukranian	3	
Pashto Southern	2	
Estonian	2	
Korean	1	
Turkish	1	
Serbian	1	
Total	**20408**	

Figures from NIHCSIS.

Age

NISRA's 2012 mid-year population estimates are shown in the table below:-

Age Group	**Persons**
0-4	127,300
5-9	114,300
10-14	115,700
15-19	124,100
20-24	123,900
25-29	125,100
30-34	122,000
35-39	118,200
40-44	130,100
45-49	133,100
50-54	120,700
55-59	102,800
60-64	93,400
65-69	86,100
70-74	65,100
75-79	51,800
80-84	37,200
85-89	21,700
90+	11,000
All Ages	**1,823,600**

	http://www.nisra.gov.uk/demography/default.asp17.htm Population projections indicate that the most significant change in age structure will occur in the older age bands. In 2008, the median age in Northern Ireland was 36.5 years, projected 37.0 years in 2011, 38.8 years in 2021 and 41.9 years in 2031. People over 60 in Northern Ireland make up 19% of the population and the number of older people is increasing rapidly. The number of people aged 65 plus continues to rise after 2023. By 2041 it is estimated that 42% of the population will be over 50 years, 25% will be pensionable age and 14% over 75 years. The number of older people over 65 has increased by 16% since 1999 and will show a similar increase from the current figures of 255,000 by 2015. This will include a rise of 29% in the number agreed over 85. The number of people aged over 65 with dementia will increase by 30% from the current figure of 15,400 to almost 20,000 by 2017. Disability prevalence also increases with age. The number of older people over 65 is an increasing proportion of the population of Northern Ireland. The number of over 65's has increased by 18% since 2000 and is expected to increase a further 13% by 2015. Older people, on average, occupy two thirds of acute hospital beds and make up 85% of those getting intensive domiciliary care. These numbers are likely to increase. It is therefore important that this framework reviews how services are focussed, designed and organised. According to the 2010/11 Health Survey Northern Ireland (HSNI) the proportion of respondents reporting their health as not good increased with age (3% of 16-24 year olds,

compared with 25% aged 75 or over). Similarly the proportion of respondents indicating they have a long standing illness increased with age from 14% of 16-24 year olds to 70% in the age group of 75 and over.
Over the next 40 years as society ages dementia will become more common. There are differences across the genders as women live longer than men.

A review by The Kings Fund across the NHS found evidence that older people may be being denied treatment offered to younger patients, and in some hospitals, the standard of hygiene and nutrition given to older people can fall below minimum standards. The Kings Fund concluded that while there are many examples of excellent care for older people, there is also much unfair treatment which was age related.
http://www.kingsfund.org.uk/publications/old_habits_die.html

Marital status

The marital status by age recorded in the 2011 Census for those age 65 and over is shown in the table below.

NISRA table DC1103NI

	Males	Females	Total
Single (never married or never registered a same-sex civil partnership)	10,836	13,384	24,220
Married	78,588	64,872	143,460
In a registered same-sex civil partnership	56	58	114

	Separated (but still legally married or still legally in a same-sex civil partnership)	2,910	2,754	5,664	
	Divorced or formerly in a same-sex civil partnership which is now legally dissolved	4,963	6,021	10,984	
	Widowed or surviving partner from a same-sex civil partnership	17,285	61,993	79,278	
	TOTAL	**114,638**	**149,082**	**263,720**	

Sexual orientation	Accurate figures are not readily available but it is estimated that 5-7% of the population are from the gay, lesbian, bisexual or 'trans' (transsexual, transgendered, and transvestites) (LGBT) community. (Equality Commission website) At the time of the 2011 Census there were 114 persons aged 65 or over living as a same sex couple (see Marital status). This is recognised as an underestimate. The new Census figures should reveal more details. Between 2005 and 2011, there have been 537 Civil Partnerships recorded (NISRA) A number of reviews have concluded that people who are *Gay, Lesbian and Bi Sexual and* 'Trans' (Transsexual, Transgendered, and Transvestites) (LGBT) are at significantly higher than average risk of mental health disorder with higher rates of anxiety, depression, selfharm and suicides alongside higher problem drug and alcohol use. These issues often relate to homophobia (including internalised homophobia) have a profound effect on self-esteem, discrimination, family rejection and isolation. A

	systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people in BMC Psychiatry in June 2008 showed that LGBT people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. The results of this meta-analysis demonstrate a two-fold excess in risk of suicide attempts in the preceding year in men and women, and a four-fold excess in risk in gay and bisexual men over a lifetime. Similarly, depression, anxiety, alcohol and substance misuse were at least 1.5 times more common in LGB people. Findings were similar in men and women but lesbian women were at particular risk of substance dependence, while lifetime risk of suicide attempts was especially high in gay and bisexual men.
Gender (Men and women generally)	NISRA's 2012 mid-year population estimates are shown in the table below:-

Age Group	Males	Females	Persons
0-4	65,100	62,200	127,300
5-9	58,800	55,600	114,300
10-14	59,400	56,200	115,700
15-19	63,400	60,700	124,100
20-24	63,000	60,900	123,900
25-29	61,700	63,500	125,100
30-34	59,400	62,700	122,000
35-39	57,800	60,400	118,200
40-44	63,800	66,300	130,100
45-49	65,600	67,400	133,100
50-54	59,500	61,100	120,700
55-59	51,500	51,400	102,800
60-64	46,100	47,300	93,400
65-69	41,400	44,600	86,100
70-74	30,400	34,700	65,100
75-79	22,800	29,000	51,800
80-84	14,600	22,600	37,200
85-89	7,400	14,300	21,700
90+	2,900	8,200	11,000
All Ages	**894,500**	**929,100**	**1,823,600**

http://www.nisra.gov.uk/demography/default.asp17.htm

	In addition, as women generally live longer than men it is more likely that that they will need care for a longer period of time. At the same time it is also possible that men may need this care at any earlier stage of their lives. Accurate figures on the number of transgender persons are not currently available. In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women. Female life expectancy has consistently been higher than that for males however this gender gap has declined in recent years. In addition, the influence of social conditions and lifestyle behaviours is evident when comparing life expectancy for men and women across geographical areas – males living in the 10% least deprived areas in NI could expect on average to live almost 12 years longer than those living in the 10% most deprived areas. For females, the gap is more than 8 years. Men and women are prone to different types of diseases at different ages, and there are different prevalences of health behaviours. For example: Smoking prevalence – 25% males, 23% females Around a quarter of males (27%) drank above weekly limits compared with 16% of females -A similar proportion of males and females were obese, however males were more likely to be overweight than females (44% and 30%) Males are more likely than females to meet the recommended level of physical activity (44% and 35%) Females were more likely to show signs of a possible mental health problem (23% and 17%) On average, the suicide rate is twice as high in deprived areas and males are three times more likely than females to die by suicide. Young males in deprived areas are particularly vulnerable, as are marginalised groups such as those who are

unemployed, or people with mental illness and addiction problems.

Men are 3 times more likely to be killed in a road accident, die of a heart attack and twice as likely to die from lung cancer.

Men are at significantly greater risk than women from nearly all common cancers that occur in both sexes (with the exception of breast cancer)

Transgender individuals have higher level of mental health issues and are more likely to attempt suicide.

Suicide rate in Traveller men is 6.6% times higher than the general population

In addition, evidence suggests that men have higher levels of risk behaviour but are less likely to attend their GP or leave it late to attend. The impact of leaving attendance at GPs too late is that men are more likely to attend Accident and Emergency Services (Evidence collated for Audit of Inequalities 2010).

Risk Behaviour and GP consultation rates – primarily NISRA Continuous Household Survey
http://www.csu.nisra.gov.uk/survey.asp29.htm

Disability (with or without)

The prevalence of Long Term conditions by age recorded in the 2011 Census for those age 65 and over is shown in the table below.

	Male	Female	Total
Deafness or partial hearing loss	27553	27951	55,504
Blindness or partial sight loss	6967	11296	18,263
Communication difficulty	3691	5082	8,773
A mobility or dexterity difficulty	39113	63499	102,612
A learning, intellectual, social or behavioural difficulty	1354	1593	2,947
An emotional, psychological or mental health condition	5602	9433	15,035
Long-term pain or discomfort	27343	46531	73,874
Shortness of breath or difficulty breathing	21050	27585	48,635

Frequent periods of confusion or memory loss	7199	13078	20,277
A chronic illness	30045	27419	57,464
Other condition	10289	15481	25,770
No condition	33913	42334	76,247
Total	**214119**	**291282**	**505401**
All usual residents	**114638**	**149082**	**263,720**

NISRA Table DC3101NI

Ageing brings with it an increased likelihood of some degree of disability. Many medical conditions such as stroke, vascular disease or dementia are not limited to older people but occur more frequently in those over 65.

McConkey *et al* (2006) predict that the population of adult persons in NI with a learning disability will increase by 20.5% by 2021 (N=10,050). This compares to an estimated increase of 16.2% in England. The percentage of persons aged over 50 years in 2021 will increase to 35.7% in Northern Ireland (up from 26.8% in 2002).
The Northern Ireland Survey of Activity Limitation and Disability 2006/7 provides information on disability and other Equality categories.

The prevalence of disability amongst adults varies significantly with age, ranging from a low of 5% amongst young adults aged 16-25 to 60% amongst those aged 75 and above. Indeed, amongst the very elderly, aged 85 and above, the prevalence of disability increases to almost 67%.

For both males and females the prevalence of disability increases with age. The prevalence of disability is particularly high for females aged 75 and above (at 62%). Figures 7 and 8 show that it is only amongst the youngest adults, aged 16 to 25, that male prevalence rates (at 6%) are higher than the equivalent for females

(4%).

Dependants (with or	The vast majority of older people live independently

without)	however some others require support from family and carers which can place a burden on those caring for elderly relatives etc. The support of family in the role of a carer means that many vulnerable people are able to lead independent lives in their community. Standards outlined in this framework aim to ensure that carers Based on recent information from Carers Northern Ireland, the following facts relate to carers: • 1 in every 8 adults is a carer • There are approximately 207,000 carers in Northern Ireland • One quarter of all carers provide over 50 hours of care per week • People providing high levels of care are twice as likely to be permanently sick or disabled than the average person • Approximately 30,000 people in Northern Ireland care for more for than one person • 64% of carers are women; 36% are men (June 2011) Carers often neglect their own physical and mental wellbeing and are Twice as likely to be sick or permanently disabled More likely to experience high levels of psychological distress, including anxiety, depression and loss of confidence and selfesteem than non-carers. Women are more likely to be informal carers than men. Also, it is recognised that persons with dependents can find it more difficult to access in hours unscheduled care and have difficulties regarding the flexibility of appointment times in order to access health care services

	Carer experience: Carers indicate that they are often viewed by staff as additional competitors for scarce resources rather than as equal partners in the care of the person. They sense staff ambivalence rather than the prospect of collaboration. Trust training programmes include development sessions on this for staff, yet day-to-day practice still lags behind the aspirations of partnership. (HSCB Audit of Inequalities 2010) *Short breaks - Respite care:* There is little consistency in targeting carers in need of respite – a Trust may have several sets of criteria. Better methods of assessing the strain and stress of caring asexperienced by carers are required (HSCB Audit of Inequalities 2010).

***** Qualitative data – refers to the experiences of individuals related in their own terms, and based on their own experiences and attitudes. Qualitative data is often used to complement quantitative data to determine why policies are successful or unsuccessful and the reasons for this.

Quantitative data - refers to numbers (that is, quantities), typically derived from either a population in general or samples of that population. This information is often analysed either using descriptive statistics (which summarise patterns), or inferential statistics (which are used to infer from a sample about the wider population).

1.6 Needs, experiences and priorities

Taking into account the information recorded in 1.1 to 1.5, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision? Specify details for each of the Section 75 categories

Section 75 category	Details of needs/experiences/priorities
Religious belief	There is no evidence that different religions will have any different needs, experiences, priorities or issues in relation to the framework.
Political opinion	No evidence has been found that people of different political opinions will have any different needs, experiences, priorities or issues in relation to the framework.
Racial group	Evidence has suggested that there may be issues in relation to language requirements for healthcare users of different races. This is seen through the increased use of interpreting services. This framework has a large focus on person centred care, including standards on eliminating discrimination and good communications. This is equally applicable to those of all racial groups.
Age	This Framework is aimed at all older people. Older people have many differing needs across the Health and Social Care network and many we have consulted with have had a range of experiences from good to bad. The standards outlined in the Framework will help address these inconsistencies, ensuring that all older people are treated consistently, yet treated as individuals. The Equality Commission NI Statement on Key Inequalities in Northern Ireland (October 2007) highlighted the failure of the NHS to address the mental health needs of older people. This framework includes several standards aimed at addressing this failure, including: Improved Dementia and Mental Health Services; and Recognition and Prevention of Delirium.
Marital status	There is no evidence that people of different marital status will have any different needs, experiences, priorities or issues in

	relation to the framework.
Sexual orientation	There is no evidence that people of different sexual orientation will have any different needs, experiences, priorities or issues in relation to the framework.
Gender (Men and women generally)	There is evidence to suggest that women, on average, live longer than men and are therefore likely to need healthcare services for a greater length of time. This framework, though, makes no distinction in relation to how long medical services are required for. It is aimed at ensuring that these services are satisfactory for as long as they are need for.
Disability (with or without)	Older people (over 65) are more likely to have some form of physical or mental disability. The priority in these standards is prevention of conditions that commonly lead to disability. Again, experiences of those with a physical disability have varied, and the Framework has a focus on equality of opportunity and eliminating discrimination for all older people, including those with a disability.
Dependants (with or without)	Through responses from individuals, carers of older people can experience a loss of wellbeing, financial security or reasonable quality of life through the care they provide. Carers can be younger family members but there are increasing numbers of older carers as well. The priority of this Framework is to identify carers and support them through; providing relevant information, providing financial advice, involving carers, and supporting carer health and wellbeing.

Part 2. Screening questions

2.1 What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)		
Section 75 category	Details of policy impact	Level of impact? minor/major/none
Religious belief		None
Political opinion		None
Racial group		None
Age	An increase in access to quality health and social care provision for all older people with the focus on the older person as an individual and person centred care. This includes a focus on equality of opportunity, engagement and choice, and eliminating discrimination.	Minor
Marital status		None
Sexual orientation		None
Gender (Men and women generally)		None

Disability (with or without)	Support for older people with a disability through a focus on prevention of causes of disability as well as transitions of care for those with a disability or long term condition.	Minor
Dependants (with or without)	An increase in support for carers of older people. This includes identifying carers and providing them with information, financial advice, flexible services, respite and a focus on carer wellbeing.	Minor

2.2 Are there opportunities to better promote equality of opportunity for people within the Section 75 equalities categories?		
Section 75 category	If **Yes**, provide details	If **No**, provide reasons
Religious belief		No
Political opinion		No
Racial group		No
Age	Yes, see 2.1 above	
Marital status		No
Sexual		No

orientation		
Gender (Men and women generally)		No
Disability (with or without)	Yes, see 2.1 above	
Dependants (with or without)	Yes, see 2.1 above	

2.3 To what extent is the policy likely to impact on good relations between people of different religious belief, political opinion or racial group? (minor/major/none)		
Good relations category	Details of policy impact	Level of impact minor/major/none
Religious belief		None
Political opinion		None
Racial group	The standards relating to eliminating discrimination, equality of opportunity and involvement will mean service users of different racial groups should feel more confident in the service they receive despite any language barriers etc.	Minor

2.4 Are there opportunities to better promote good relations between people of different religious belief, political opinion or racial group?		
Good relations category	If **Yes**, provide details	If **No**, provide reasons
Religious belief		No, this is a framework aimed at all older people, regardless of religious beliefs.

Political opinion		No, this is a framework aimed at all older people, regardless of political opinion.
Racial group		No, this is a framework aimed at all older people, regardless of race.

2.5 Additional considerations

Multiple identity

Provide details of data on the impact of the policy on people with multiple identities (e.g. minority ethnic people with a disability, women with a disability, young protestant men, young lesbian, gay or bisexual persons). Specify relevant Section 75 categories concerned.

There are a number of persons with a multiple identity which this framework will have an impact on, including:

- Older people with a disability
- Older people from an ethnic minority background
- Older carers

The impact on these groups will be positive due to the focus on person centred care. This will ensure that all people from the above groups will be treated equally as individuals and have their particular needs met.

2.6 Was the original policy / decision changed in any way to address any adverse impacts identified either through the screening process or from consultation feedback. If so please provide details.

A Public consultation was conducted. While minor changes were made to the document following public consultation, none of these changes related to issues raised over equality. No adverse incidents were identified through this process.

Part 3. Screening decision

3.1 How would you summarise the impact of the policy / decision?

No impact	X	
Minor impact		Consider mitigation (3.4 – 3.5)
Major impact		

3.2 Do you consider that this policy / decision needs to be subjected to a full Equality Impact Assessment (EQIA)?

Yes - screened in	
No - screened out	X

3.3 Please explain your reason for making your decision at 3.2.

The Service Framework for Older People aims to increase improve the health and social wellbeing of all older people. This includes ensuring that older people as a whole are not discriminated against when it comes to provision of healthcare services. As such this framework will only have a positive impact on the healthcare of older people including those of different racial groups, sexual orientation etc.

Equality issues were not raised in any of the responses to the public consultation nor were there any suggestions that a full EQIA was required.

Mitigation

If you have concluded at 3.1 and 3.2 that the likely impact is '**minor**' and an equality impact assessment is not to be conducted, you must consider mitigation (or scope for further mitigation if some is already included as per 2.6) to lessen the severity of any equality impact, or the introduction of an alternative policy to better promote equality of opportunity or good relations.

3.4 Can the policy/decision be amended or changed or an alternative policy introduced to better promote equality of opportunity and/or good relations?

Yes	
No	X

3.5 If you responded "**Yes**", please give the **reasons** to support your decision, together with the proposed changes/amendments or alternative policy.

Part 4. Monitoring

Monitoring is an important part of policy development and implementation. Through monitoring it is possible to assess the impacts of the policy / decision both beneficial and adverse.

4.1 Please detail how you will monitor the effect of the policy / decision?

Monitoring of the Service Framework for Older People will be undertaken by the HCB Board and PHA. Prior to Year 1 of the Framework commencing these HSC organisations will develop plans for its implementation and monitoring. The development of these plans will include the collection of data and achievement of targets.

4.2 What data will you collect in the future in order to monitor the effect of the policy / decision?

See above.

Please note: - For the purposes of the annual progress report to the Equality Commission you may later be asked about the monitoring you have done in relation to this policy and whether that has identified any Equality issues.

Part 5. Disability Duties

5.1 Does the policy/decision in any way promote positive attitudes towards disabled people and/or encourage their participation in public life?

Yes. The Service Framework for Older People encourages positive attitudes to all older people, including those with a physical or mental disability, throughout the framework document. This is especially highlighted through standards encouraging engagement with older people and offering older people equality of opportunity access services.

5.2 Is there an opportunity to better promote positive attitudes towards disabled people or encourage their participation in public life by making changes to the policy/decision or introducing additional measures?

No

Part 6. Human Rights

6.1 Please complete the table below to indicate whether the policy / decision affects anyone's Human Rights?

ARTICLE	POSITIVE IMPACT	NEGATIVE IMPACT = human right interfered with or restricted	NEUTRAL IMPACT
Article 2 – Right to life			X
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	X		
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour			X
Article 5 – Right to liberty & security of person			X
Article 6 – Right to a fair & public trial within a reasonable time			X
Article 7 – Right to freedom from retrospective criminal law & no punishment without law.			X
Article 8 – Right to respect for private & family life, home and correspondence.	X		
Article 9 – Right to freedom of thought, conscience & religion			X
Article 10 – Right to freedom of expression			X
Article 11 – Right to freedom of assembly & association			X
Article 12 – Right to marry & found a family			X
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	X		

1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property			X
1st protocol Article 2 – Right of access to education			X

6.2 If you have identified a likely negative impact who is affected and how?

At this stage we would recommend that you consult with your line manager to determine whether to seek legal advice and to refer to Human Rights Guidance to consider:

- *whether there is a law which allows you to interfere with or restrict rights*
- *whether this interference or restriction is necessary and proportionate*
- *what action would be required to reduce the level of interference or restriction in order to comply with the Human Rights Act (1998).*

6.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy/decision.

Part 7 - Approval and authorisation

	Name	Grade	Date
Screened completed by	Colin Wallace	SO	13/05/2014
Approved by[1]	David Best	G7	16/05/2014
Forwarded to E&HR Unit[2]			

Notes:

[1] The Screening Template should be approved by a senior manager responsible for the policy this would normally be at least Grade 7.

[2] When the Equality and Human Rights Unit receive a copy of the final screening it will be placed on the Department's website and will be accessible to the public from that point on. In addition, consultees who elect to receive it, will be issued with a quarterly listing all screenings completed during each three month period.